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ABSTRACT

Between February 7 and February 24, 2002, Utah and Salt Lake City hosted the Winter Olympics. Due to the bombing at the 1996 Summer Olympics in Atlanta and the emotional "fallout" that resulted, it was recommended that the Utah Psychological Association and Utah Red Cross plan for such an occurrence and organize a coordinated Disaster Mental Health (DMH) response. This paper presents the author's reflections on the planning and response efforts, including recommendations for other state psychological associations based on lessons learned from Salt Lake City's experiences. Two appendixes include a summary of "UPA Olympic Preparations and Future Recommendations for State Associations," and a sampling of Olympic experiences contributed by DMH volunteers. (GCP)

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DISASTER PREPAREDNESS: LESSONS FROM THE 2002 SALT LAKE CITY OLYMPICS

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DISASTER PREPAREDNESS: LESSONS FROM THE 2002 SALT LAKE CITY OLYMPICS

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By way of introduction, I am the Utah Psychological Association's Disaster Response Network (DRN) Coordinator. I am also the Disaster Mental Health State Lead for the American Red Cross of Utah. In addition, I serve as a member of the Utah Critical Incident Stress Management (CISM) Team, and as the Western Region Representative to the American Psychological Association (APA) DRN Advisory Committee.

Between February 7 and February 24, 2002, Utah and Salt Lake City hosted the Winter Olympics. Due to the bombing at the 1996 Summer Olympics in Atlanta and the emotional "fallout" that resulted, I recommended our State Psychological Association and State Red Cross plan for such an occurrence and organize a coordinated Disaster Mental Health (DMH) response. That proposal was accepted and planning began more than two years prior to opening day of the 2002 Winter Olympics. The tragic events of September 11, 2001 put an exclamation mark on the need to be prepared. The following pages are my reflections on our planning and response efforts, including recommendations for other state psychological associations based on lessons learned from our experiences.

Our preparations began with the development of a coordinating, organizational structure. Since I was serving in leadership roles for several organizations that have a mental health role following disasters and other traumatic events, I was asked to serve as the American Red Cross Disaster Mental Health Officer for the Olympics. This organizational "cross-over" isn't necessary, but it did prove helpful in facilitating communication and adding credibility when dealing with other organizations prior to and during the Olympics.

It is probably important to note here another important connection between our national and state psychological associations and the American Red Cross that aided our planning and response processes as we prepared for the Olympics. A brief history might be helpful: The American Red Cross formally introduced Disaster Mental Health Services (DMHS) as a new disaster service in late 1991. On December 13, 1991, an official Statement of Understanding formalizing a cooperative relationship between the Red Cross and APA was signed. APA's Disaster Response Network (DRN) was officially "unveiled" on August 14, 1992 as a special centennial gift to the nation in response to numerous large disasters that had devastating impact on the lives of incredibly large numbers of victims.

These events and agreements had special significance for our State's planning since our State Psychological Association has neither the financial nor physical resources to provide a truly independent disaster mental health response. Therefore, we needed a way to connect with an organization that has a legitimate and expected role, including a clear physical presence, at times of disaster or other traumatic events.

Following the lead of our parent organization, APA, our UPA DRN developed a formal connection with our State Red Cross units and the State Olympics Coordinator for the American Red Cross. We believed this affiliation would give us legitimate access to those needing emotional support if unwanted events should occur, and would give us security while on duty as well as flexibility in assigned locations. This proved to be true. It was following these contacts that I was appointed Olympics DMH Officer for the Red Cross.

Recognizing the need to share the burden of administrative and front line service responsibilities, two organizational structures emerged. First, we appointed a co-coordinator for our UPA DRN (Kay Koellner, Ph.D.), recruited more psychologists into our DRN, and organized a DRN Committee. Second, we appointed five DMH Assistant Officers to help with Red Cross administrative needs, coordinating shift assignments, and providing general supervision over long hours and disparate geographic locations.

Now that we had a clear commitment to provide emergency mental health services, we recognized that when disasters occur, mental health providers seem to descend on a scene almost "like ants from nowhere." This had been our experience in previous shooting and bomb-scare events, and we had observed it happen in other states as well.

We wanted to "head off" such confusing, annoying, and time consuming chaos; therefore, our UPA Executive Board and DRN Coordinator contacted the Utah State Olympic Officer to see if any mental health response had been included as part of the State's Olympic emergency response plan. It had not. We offered our help as the State's Association of Psychologists. The State Olympic Officer appreciated our offer and encouraged us to proceed.

Armed with that mandate and as the UPA DRN Coordinator and ARC DMH Lead, I began contacting identifiable mental health agencies and provider groups along the Olympic venue corridors and inviting them to meetings of our UPA DRN Committee to discuss coordinating emergency mental health services during the Olympics. From these beginning meetings a Mental Health Coalition emerged. It was co-chaired by a psychologist at the Department of Veterans Affairs in Salt Lake City (Steven N. Allen, Ph.D.) and myself.

Our Mental Health Coalition includes (we are continuing the coalition for future preparedness) representatives from the American Red Cross; Intermountain Healthcare (IHC) Behavioral Health Network; local university counseling centers, hospitals, clinics, institutes, police; Salt Lake City Mayor's Office, police, firefighters; Trauma Awareness

and Treatment Center; Utah CISM Team; UPA DRN; U.S. Dep't. of Justice (U.S. Attorney's Office) Victims Assistance Coordinator; Utah Psychiatric Association; Utah State Dep't. of Human Services Division of Mental Health; Valley Mental Health; Veterans Affairs Salt Lake City education system and division of mental health; and Wasatch Mental Health. Representatives of the Salt Lake Olympic Committee and the Utah Olympic Public Safety Command also attended our meetings.

We decided on and defined response procedures for each group and discovered very compatible and complementary roles. There was no competitive posturing. The mental health coalition worked together to prepare for mental health needs during the Olympics at two levels: (1) daily stressful events, accidents, etc.; and (2) natural or manmade disasters or emergencies.

During our discussions we discovered that the Olympic organizers had contracted with IHC to provide all health services within the defined Olympic venues. IHC administrators discovered they had overlooked potential mental health needs and finally decided they would escort those with serious emotional crises to the venue entrance/exits and transport them to available hospitals where "on-call" crisis workers would be asked to respond.

This seemed unacceptable to others in the coalition for a couple reasons: (1) Given heightened security measures following the tragedies of September 11, 2001, we knew that if an unwanted event took place, all access and transportation routes would immediately be shut down and no one would be allowed to enter or leave expanded security perimeters. Traffic would come to a stop. It would take hours to provide a mental health response even after a mobilization call-out occurred. (2) Large cities near, but outside venue confines would be left without any planned or organized mental health response.

Considering the above, our coalition decided that it would be important to have qualified disaster mental health professionals continually on-site, near Olympic venues and activities. This would allow for an immediate response if something happened.

During the Atlanta Summer Olympics, Dr. Betsy Gard had arranged for mental health workers to be available at venue sites as Olympic Guards trained by the Atlanta Olympic Committee. For a variety of reasons, this was not workable in our situation. Our mental health coalition discovered that the only coalition members with any interest in continuous on-site availability were the American Red Cross and the UPA DRN. All other coalition groups intended to maintain usual daily operations and have emergency mental health responders available on-call.

At the request of each municipality surrounding the Olympic venues, the American Red Cross decided very early in the process to maintain 15 strategically placed, stationary First Aid stations, several designated locations for shelters, and two comprehensive operational headquarters (one in Salt Lake City and one in Provo).

By mutual agreement, and with encouragement from other coalition members, it was decided that UPA would recruit as many psychologist volunteers as possible and that Red Cross would train and use them in teams of two at First Aid stations and HQ's. Mental health volunteers at First Aid Stations would be immediately available to go to designated, nearby shelters, if they were activated because of an emergency need.

In practical terms, this meant we needed up to 300 mental health volunteers to cover approximately 1,000 shifts of 6-10 hours each. At first, this seemed like a daunting task, but we ended with 200 workers covering almost 1,000 shifts. Here's how we did it: (1) Requested approval for exceptions from the National offices of the American Red Cross to teach and open Disaster Mental Health Services (DMHS) I courses to much larger than normal groups of participants (up to 95) and to allow matriculated graduate students in clinical and counseling programs to train and serve with an on-site, licensed supervisor; (2) Received the above requested approval; (3) Requested approval from our State Division of Occupational and Professional Licensing (DOPL) to sponsor and use licensed, trained professionals from other states to assist us with needs we could not otherwise meet under provisions of Utah Code Section 58-1-307, "Exemptions from licensure"; (4) Received the above requested approval and used licensed and Red Cross trained volunteers from Arizona, California, Colorado, Idaho, Nevada, and Wyoming. (Note: We did have additional offers of help and had "walk-ons" show up asking to help, but we had to decline many of these due to their lack of license or Red Cross training); (5) Recruited widely within Utah and outside the State through internet listervs, word of mouth, and an article in the January 2002 issue of the APA "Monitor on Psychology"; (6) Through the Red Cross, provided 5 DMHS I courses in the State, one DMHS I course in a neighboring state, and one pilot Disaster Mental Health Services in Mass Casualty Disasters course; (7) Through the mental health coalition and CISM Team provided a general emergency mental health workshop and a CISM training; (8) Developed a contact list of newly trained and previously trained, licensed and student volunteers; (9) Arranged for American Red Cross, through corporate donations, to provide mental health volunteers with a fleece jacket shell; (10) Provided a mechanism for and scheduled volunteers into multiple shifts; (11) Mailed shift assignment letters and instructions to all volunteers; and (12) Arranged for Red Cross Olympic Photo ID badges for all volunteers.

The DMH Officer and Assistant Officers were assigned shifts at the two major operational headquarters to coordinate with officers in other functions, handle emergency mental health calls or inquiries from outside agencies and personnel, orient mental health volunteers to their assignments, make assignment changes in the event of an absent worker, help volunteers in other functions understand the role of the mental health workers, handle stress of others in headquarters assignments, and do debriefings for volunteers returning from long or stressful shifts at First Aid Stations, etc.

As a result of our early planning, recruiting, training, forming a coalition with other mental health groups, connecting and working with an authorized disaster response organization, organizing our administrative and response procedures and personnel, we were able to have a very successful experience providing emergency mental health

services during the 2002 Salt Lake City Olympics. A few comments from Disaster Mental Health volunteers about their experiences are included in Appendix B.

Recommendations

A number of recommendations seem very important for any state psychological association to be successfully prepared to make a meaningful, coordinated, and timely mental health response to disaster or trauma. I have outlined many of these below. The order depends on the status of a state association's preparedness:

1. Don't wait! Do it now! When a crisis happens it's too late to plan.
2. Formally organize a Disaster Response Network (DRN) with a willing Coordinator and clear oversight by the state psychological association.
3. Establish an organizational, administrative structure that allows for flexibility and continuity of service under unusual or unexpected conditions.
4. If needed, get assistance from those with experience inside your state, your region's DRN Advisory Committee Representative, or the APA DRN Director (see Appendix C).
5. Begin developing your own disaster plan and response procedures.
6. Anticipate and identify upcoming community events that may draw public attention and crowds (e.g., sporting, concert, cultural, etc.).
7. Anticipate and identify possible, unexpected tragedies (e.g., shootings, bombings, fires, natural disasters, etc.).
8. Talk with and get help from experts to do the above.
9. Recruit association members into your DRN.
10. Use your DRN to recruit new association members.
11. Provide disaster and emergency mental health training.
12. Develop agreements with authorized, non-parochial disaster or crisis response groups to provide mental health assistance when needed (e.g., American Red Cross, state CISM Team).
13. Identify other mental health provider groups and agencies.
14. Develop a cooperative mental health coalition with other mental health groups.
15. Arrange agreements with your state licensing division for using out-of-state volunteers, if your state code permits.
16. Develop procedures to verify license, credentials, and training of volunteers.
17. Develop procedures to deal with, screen, train, or decline "walk-on" volunteers at the scene of a crisis event.
18. Develop ID procedures (e.g., badges, hats, jackets, vests, etc.)—usually unnecessary if responding through organizations such as Red Cross or CISM, which have their own ID procedures.
19. Engage in test exercises of your emergency response plan and procedures.

Appendix A

Summary (see text for detail): UPA Olympic Preparations & Future Recommendations for State Associations

UPA Olympic Preparations

- 2+ yrs. Formal Advance Planning
- Formed DRN Committee (DRN & Coordinator in place)
- DRN Recruitment
- Cooperation Agreement Between UPA & American Red Cross
- App't of UPA DRN Coordinator as Red Cross Olympics Mental Health Officer
- App't of Assistant Officers
- Offered Help to State Olympics Officer
- Formed Mental Health Coalition for Olympics and Beyond
- Defined Coalition Roles:
  a. Complementary Not Competitive
  b. Daily Stressful Events
  c. Disasters or Emergencies
- Decided: On-Site Mental Health Presence Through Red Cross
- Approval from DOPL to Use Out-of-State, Licensed Professionals (Utah Code, Section 58-1-307)
- Approval from Red Cross National HQ to Use Graduate Students
- Approval from Red Cross for Additional, Larger Trainings
- Provided Multiple Training Events
- Arranged for Jackets and ID Badges
- Assigned Mental Health Volunteers to Shifts at First Aid Stations and HQ's
- 200 M.H. Volunteers; 1,000 Shifts; 15 First Aid Stations; 2 Operational HQ's
- SUCCESS!

Recommendations

- Plan Now—Be Prepared!
- Appoint a DRN Coordinator & Other DRN Leaders
- Organize a DRN
- Organize for Flexibility and Continuity
- Develop Disaster Plans and Response Procedures
- Recruit Association Members into DRN
- Use DRN to Recruit New Association Members
- Anticipate Crisis Events
- Provide Training
- Create Cooperation Agreements with Authorized Disaster or Crisis Response Groups
- Form a Mental Health Coalition with Complementary, Non-Competitive Roles
- Obtain Needed Agreements From State Licensing Division to Use Out-of-State Volunteers
- Develop Screening Procedures for Usual Volunteers and Crisis "Walk-Ons"
- Arrange for ID Procedures
- Test your Plan and Procedures
- SUCCESS!

Appendix B

Sample of Olympic Experiences

(with permission of contributing DMH volunteers)

Steven R. Rolnick, Ph.D., CEAP:
On the final Saturday at the 100 South and Main First Aid Station near TRAX a large multigenerational family group had just gotten off the light rail to start their day downtown and proceeded to cross the street heading south on Main. The great grandma tripped on a paving stone, fell and cut her forehead which understandably frightened and concerned the grandchildren and grand daughter. Great grandpa was traveling with them in a wheelchair. Our first aiders ran over immediately to assist. EMS was also called but determined she was medically stable to go with recommended follow-up with her doctor if she experienced any further medical problems. I assisted in reassuring and calming the children and parents in the group, hearing their concerns and offering refreshments.

Anonymous:
During most of my shifts we just had the normal kinds of stress to calm—you know, from little accidents, lost persons, hypothermia, etc. But, the night of what I like to call the "Beer Riot" was different. The Beer Hut in the downtown area became so crowded with people that it was becoming dangerous, and, for safety, they closed the entrance to incoming people. The crowd began building outside and gradually became more unruly with pushing and shoving and angry demands to be let in the Beer Hut. Since that wasn't going to happen, the crowd got more unruly and tried climbing a fence. That didn't work so the crowd became a roving mob, moving up the street, yelling and throwing bottles. Police couldn't contain the crowd and began shooting rubber bullets. As the angry crowd passed our First Aid Station, it inadvertently surrounded two of our young female First Aid volunteers who suddenly feared for their lives. They went into full-blown panic attacks. My mental health partner and I spent the next 1 ½ hours defusing the situation. We calmed all the workers at the Station and spent much time with the two volunteers helping them understand what had happened to them, how to deal with it, and what to do in the future. Wow, were we appreciated that night!

Annette Jerome, Ph.D.:
One Sunday I was riding the bus into the Olympic village to begin my shift. There was a family on the bus planning on skiing. They had a young boy who apparently had some form of obsessive-compulsive behavior problem. His behavior became problematic (and especially loud). It was also apparent that mom and particularly the older brother were becoming quite impatient. I intervened with the young man and was able to de escalate his behavior. As we stepped off the bus at the Olympic Village, mom thanked me for helping and told me a little about her son's disability. She was please that he had calmed down and was hoping or a nice day of family skiing. Not a big deal, but none-the-less a small mental health contribution.

Anonymous:
The thing that I appreciated most was being able to get to know people who serve in the Red Cross--just ordinary folks. In the event of a future emergency, we have gotten acquainted with the procedures, roles, and people with whom we will be serving. It gave me a chance to get acquainted with other mental health practitioners in the community and to renew some old friendships. I did serve as a "listening post" for frustrations from staffers concerning some bothersome conditions. That seemed helpful.

Linda G. Lawrence, LCSW:
I enjoyed participating in the mental health part of the Red Cross for the Olympics. I was only able to work 2 shifts, but each time the First Aid volunteers mentioned it was nice to have someone to cope with mental health issues. As we walked around talking to people we were very often thanked and told that just our presence was comforting. Towards the end of one shift a young woman who was quite ill was brought to our tent. She was cared for with the utmost professionalism by the First Aiders as we waited for the EMT's to arrive with the ambulance. Afterwards, we did a short debriefing. I was told this was something new (to have a debriefing on site), that the medical side of things had always been covered, but the mental/emotional side of an event such as this is usually only covered by the medics talking with each other. Thank you for the training and experience.

Ann Prazza. LCSW, CEAP:
During my experience as a mental health technician at the Olympics, I observed that most Red Cross volunteers do not understand the function of Mental Health workers. I was asked several times by the First Aid responders, "Why are you guys here, anyway?" I feel like much of my Olympic experience was spent educating folks about our role, and helping my teams feel less intimidated by me.

One night I was stationed downtown with a team of about 6 workers. Since I was the only MH worker, I was teamed with two other First Aid responders. I was able to get to know them well, and since it was initially a slow night, we all shared our stories and became friends. Our team leader was a young man who had not had much experience as a Red Cross responder. He asked me directly, "Just what does 'mental health' do?"—implying that we were not essential to the team. I explained, but he continued to tease and just make jokes about "those mental health folks."

Later that night the same young man became a first responder to a victim who had a grand mal seizure. The victim had fallen on the cement, hitting his head, and there was a lot of blood. After the incident, the young volunteer was shaking and appeared to be in some shock, so I stayed close and began attempting to debrief him. Initially, he resisted, wanting to protect his image as the "strong" team leader. Gradually, he began to talk, and talk, and talk, and he admitted he hadn't felt good about his role in the response. I was able to help him see that he had done his best, and to reframe the experience for him as a positive one.

The rest of the night, he kept bragging to the rest of the team about "mental health workers" and how glad he was that I was there on the team. He actually told me: "Now I know why you guys are here." We parted that night with a hug, and I know that this memory will be a more positive one for him because I listened to him and supported him. I also know that this particular team of workers has a clear idea of why the mental health tech role is essential in these operations.

The last night of the Olympics, I worked my last shift. I noticed a great difference in the way I was viewed, and I felt much more involved and part of things. I think this was due to my having more experience, but also to the fact that the First Aid responders were beginning to view Mental Health workers as a necessary part of a disaster response team. They were not so intimidated or mystified by our presence. The volunteers had viewed us as being there for the victims that they respond to. By the end of the Olympics, I think they were beginning to see that the Mental Health workers were there for them as well.

Noel Gill, Ph.D.:
Nothing too exciting on my shifts, though there were a couple of incidents in which I think having a mental health specialist on the team helped.

The first was my first day's assignment at the location where they had the concerts, the Indian village, and the city buildings. We received an emergency call from one of the food establishments where a four year old boy was jumping around on some bales of straw and hit his head on a valve of some kind. There was quite a bit of bleeding and the little tyke was screaming. I joined the First Aid response pair who were doing an admirable job of stopping the bleeding and attending to the medical needs. The more frightened and panicky the child became the more upset his family became. They were from some Nordic country and spoke little English. Pretty soon the extended family of the young boy was surrounding the medical team and becoming quite upset.

I approached them and said that I represented the mental health component of Red Cross and was there anything I could do. I was met with a flood of questions to which I invited the group to sit down so I could answer them. As we visited, they began to calm down. I reassured them of the professional care they were receiving and discussed the follow up attention they could receive if it became necessary.

The patriarch of the clan took a liking to me and began to talk about his family's journey to the Olympics. He introduced everyone to me and soon we were all exchanging our favorite Olympic stories. This calmed the little boy down and his mother as well. It was a cold night and I gave the little boy one of my hand warmers, which took his mind off his injury. No one had seen the chemical hand warmers before and they all had to try it out. I had an extra bottle of water with me and offered it to the boy. He asked me if I would autograph it for him. I explained to him that I was neither an athlete nor a celebrity. "I know," he said, "but Gramps thinks you're cool and you helped me stop crying." So I signed what was to be my one and only autograph of the Olympics

Afterwards, as we processed the incident with the Red Cross team, we discussed the importance of addressing not only the medical emergency, but helping to establish a reassuring environment. The team said they were glad we, the mental health component, were assigned to work with them.

The second incident was at one of the downtown assignments. It was starting to get dark and it was quite cold. Not too many people were out and about. One individual sort of lingered around our First Aid tent and appeared quite apprehensive and nervous. One of the ladies on the First Aid team said she had walked by and could smell alcohol on his breath. "Just another drunk" the group commented. "Maybe so" I replied. "Let me talk with him." When I approached him he was very upset. He said he had been clean and sober for nearly a year, but the presence of all the uniformed police had begun to make him nervous. He said one of his friends had talked him into taking a "stiff one" to calm himself down. Now he felt like he was a total failure and that all his efforts were in vain.

I shared with him a poster I have on my office that says, A LAPSE IS NOT A COLLAPSE, and asked him if he knew what that meant. He brightened up and said I sounded like his AA sponsors and that I was right on. We talked for some time about the obstacles he had overcome and the progress he had made. He decided that this was indeed just a small lapse and that he was still an OK guy. I invited him over and made him a hot chocolate and encouraged him to enjoy the rest of the Olympics.

Appendix C

APA Disaster Response Network

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